

This summary is intended to provide you with an overview of coverage that may be provided by M-CARE. No right will accrue to you and/or your eligible dependents based on any statement or error in or omission from this summary. A detailed description of benefits, limitations, and exclusions can be found in the Certificate of Coverage, Schedule of Benefits and riders.

Preventive services

Health maintenance exams.....	\$10 copay
Routine pediatric exams (well-child care)	Covered no copay thru age 6
Routine immunizations, travel inoculations.....	Covered
Routine periodic gynecological exams and accompanying tests/procedures (pap smears).....	\$10 copay
Mammogram.....	Covered
PSA screening.....	Covered
Colonoscopy and sigmoidoscopy.....	Covered

Non-preventive services

PCP office visit – sick care.....	\$10 copay
Specialist office visit – non-preventive....	\$10 copay
Pre and post-natal care.....	Covered
Diagnostic lab, x-ray, & pathology.....	Covered
Allergy test, treatments, and injections....	Covered
Outpatient surgery.....	Covered, no copay
Physical, occupational, & speech therapies	Covered, 180 visits for any combination of services per member per condition per year, renewable after surgery
Voluntary sterilization	Covered
Cardiac rehabilitation.....	Covered
Home health care.....	Covered, no copay; for illness or injury on a short term intermittent basis
Skilled nursing care.....	Covered, no copay, up to 730 days per lifetime
Durable medical equipment,..... prosthetic, & orthotic devices	Covered, no copay
Infertility assessment.....	Covered at specialist office visit copay
Bariatric surgery.....	\$1000 copay at contracted Centers of Excellence when criteria are met

Emergency care and urgent care

Emergency care is covered at any hospital emergency room. Copay is waived if admitted to the hospital.....	\$50 copay
Urgent care facility ¹	\$10 copay
Ambulance transportation covered when approved by M-CARE.....	\$0 copay

¹ Balance billing may apply when using a non-participating facility within the service area.

² Maximum Benefit Limit: \$250,000 per drug per member per year.

Prescriptions filled at a non M-CARE participating pharmacy may result in higher out-of-pocket costs.

Inpatient services

Days of care.....	Unlimited
Room type.....	Semi-private, private when medically necessary
Hospital services/admissions	Covered, no copay
Physician services.....	Covered
Other services.....	Covered
Organ and tissue transplants	Covered
Maternity care	Covered

Mental health care*IOP/PH~Intensive outpatient/partial hospitalization*

Outpatient care.....	Covered, no copay; 20 visits per year
Inpatient.....	Covered, no copay, 45 days per year, renewable; IOP/PH: 2 days for each unused inpatient day

Chemical dependency care

Outpatient care.....	Covered, no copay; 35 visits per year
Inpatient.....	Covered, no copay; residential: 45 days, renewable; detox: 5 days; IOP/PH: 2 days for each unused residential day

Prescription drugs²

Prescriptions.....	\$5 generic; \$10 brand
Contraceptives.....	\$5 generic; \$10 brand

Over 30 day supply	Over a 30 day supply and up to a 90 day supply, drugs may be dispensed for a single copay at certain retail pharmacies.
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Generic substitution program	In addition to copayments member is responsible for paying the price difference, between generic and brand name products, when a generic equivalent is available, unless prescribing physician writes "DAW"
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Other services

Routine vision examination....	Not covered
Frames and lenses.....	Not covered
Hearing aids/evaluation.....	Covered
Chiropractic care.....	\$10 copay; 20 visits per year